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THIRD EDITION

CLINICAL SURGICAL SKILLS

HAMAD ALQAHTANI

1 GENERAL PRINCIPLES

General principles of history taking

1. The history is the single most important factor in making a diagnosis. It directs the clinician to search for the physical abnormalities and facilitating further management.

2. Introduce yourself and tell the patient your name and explain why you are seeing him as patient like to know to whom they are talking. It is important to establish rapport and employ your eyes , ears , nose and hands in collecting the information from the patient that can lead you to the correct diagnosis.

3. The clinician should sit down either beside the patient or even on the bed, so as to be close to eye level and give the impression that the interview will be an unhurried one and give him / her your whole attention and never take short cuts. The patient's first impression of a doctor's professional manner will have lasting effect.

4. There is no doubt that one's treatment of patient begins the moment one reaches the bedside. An unkind and thoughtless approach to questioning and examining a patient can cause harm before any treatment has had the opportunity to do so. One should aim to leave the patient feeling better for one's visit. This is a difficult thing to teach and each doctor has to develop his or her own method, guided by experience gained from clinical teachers and patients.

5. An extensive knowledge of medical facts is not useful unless a doctor is able to extract accurate and succinct information from a sick person about his or her illness.

6. Obtaining the history requires a lot of practice and depends very much on doctor/patient relationship.

7. The greatest skill is to listen to what the patient volunteers and do not use direct questions to which there is only one answer. This is the key to the diagnosis and the clinician must not shape, elaborate, or direct the history into a particular category just so that it fits a classical package. Such prompting may result in misdiagnosis. Do not write and talk to the patient at the same time ; however it is useful to make a rough notes whilst questioning the patient.

8. Experienced clinicians rarely begin the routine physical examination without some suspicions about the diagnosis .

9. If the patient is not fluent in your language, you may require interpreter, and in that case keep your questions ,clear , short and simple .

General principles of physical examination

1. Good appearance is essential. Have your hair cut and dress professionally and wear clean shoes. Smell should be acceptable and hands should be clean and warm (i.e. appear, talk and behave like a professional doctor). Prepare your examination equipments with you (stethoscope, a small pocket ophthalmoscope, a torch and a short patellar hammer).

2. Try to see the patient walking into the examination room to assess for any evidence of general malaise , fatigability , breathlessness , or abnormal movement.

3. Introduce yourself and ask the patient permission to examine him / her and at all stages of clinical examination explain to the patient what you are going to do and why you are doing it.

4. When you start examining the patient , ask the relatives and friends to leave the examination room , further questions about the changes in health and behavior not noticed previously by the patient can be asked in private.

5. Fully expose the parts of the body that you wish to examine and remember to compare both sides.

6. Before the specific examination of the regions of the body begins, general inspection must be made. Make a conscious effort and take the time to consider the patient's appearance including the face, hands and body. Certain faces and body habitus are diagnostic or nearly so. Important relevant signs may be missed unless this is done. For example, the patient with loss of weight may not be identified as having thyrotoxicosis unless the eye signs are noticed.

7. Do the proper examination and before palpation never forget to ask if there is any tenderness and the patient should be comfortable at all times during the examination. Never examine patients as if you are manipulating experimental animals and remember that if the patient shouts out, you have failed your examination.

8. The easiest way to ensure that you perform a complete examination is to learn the routine by heart and repeat it to yourself during the examination.

Always keep to the basic pattern of looking, feeling, tapping and listening (inspection, palpation, percussion, auscultation), whatever you are examining. Many candidates fail their examination, not because of ignorance of facts but because they examine the patients haphazardly, illogically or incompletely. Diagnosis is not very important – even the layman can diagnose hernia or varicose vein. The doctor should go through his patient methodically step by step according to a well practiced routine, which should become instinctive, before reaching his final conclusion.

9. Whilst keeping to the routine it is, however often best to examine first the part of the body that is the source of the patient's complaint. A surgeon should have a lion's heart (for courage), a lady's hand (gentle fine touch) and an eagle's eyes (observation). You should try to spot as many abnormal physical signs as you can (even if not relevant to patient's main complaint) and therefore must examine the patient as a whole and not just part related to his or her complaint. However, you must be quick and comprehensive in your examination.

10. There are certain parts that you are not expected to include in the examination situation, such as a rectal/pelvic examination. However, you must indicate to the examiners that you would normally examine these areas. When forced to discuss the causes of a patient's swelling at the bedside, avoid the word malignancy or cancer 'tumor' but use 'mitotic lesion' or 'neoplasia' instead.

11. You should express a desire to examine other systems to seek underlying causes of local conditions.

12. After finishing the examination, thank patients at the end, help them with their clothes and tuck in the sheets. A semi-naked patient left uncovered after physical examination gives the examiner a very bad impression.

13. If you are in exam , turn to the examiner and present your findings. It is usually up to you whether you talk as you examine or present your findings at the end. Practice both ways, you may be requested specifically to explain what you are doing or you may be interrupted at any stage of the examination to present your findings so far. Common sense should be stressed, e.g. Do not mention the fetus as a cause of an abdominal swelling in a male or prostatic enlargement as a cause of urinary retention in a female.

14. If you are in exam , do not point on your own body or turn repeatedly to the patient while describing your findings. Give the impression that you know what you are talking about and prepare well to substantiate your answers. The examiner may take a contrary view just to test your knowledge. You are expected to discuss the advantages and disadvantages of opposing views without emotion and to be sufficiently flexible to allow another

opinion but at the same time to be firm in your own beliefs if correct. Do not argue with the examiner even though you know that you are correct.

15. Always make a diagnosis. Give "one diagnosis" when examiner asks "what do you think what is this?" do not answers irrelevantly, listen carefully, plan your answer. At the bedside do not jump to conclusions but examine the findings, then plan and think of the possible causes that support the conclusion (use your eyes and hands, then your brain, then open your mouth).

16. If the examiner asks you later on 'did you ask the patient about diagnosis? answer diplomatically, 'I asked him/her as a part of my routine systemic enquiry. Do not say 'no' since the examiner may take you to the patient to find out the truth. It is better not to know the diagnosis made by other doctor , because it may not be correct .

17. Do not use term "this may be", "I think", "It could be" etc. Do not repeat the question while thinking of an answer, and do not ask the examiner to repeat the question since this indicates either that you did not listen carefully or that the question was not phrased in an understandable way. However, if uncertain as to your instructions, do not hesitate to ask for clarification and hopefully the examiner will rephrase the question better. Do not become aphasic because of the shocking stress of the examination since examiners think that you should function properly under the stress of surgical emergencies and major operations, which is similar if not greater than examination stress, i.e. you are not suitable to be a surgeon. Relax and impress the examiner with your quiet confident ability.

18. Do not use meaningless phrases. Your ability to communicate as well as your surgical knowledge and judgment is being assessed.

19. Always write your diagnosis on the sheet provided for long case.

20. Expect and be prepared to answer three commonest questions.

a) What is this?

b) What else can it be?

c) What will you do?

21. Examine as many patients as you can. Nothing can be learnt without frequent practice. Repetition is the secret of learning. You will become confident of your interpretation of your visual, tactile and aural appreciation

of the patient's body only by repeatedly exercising these senses.

22. At the conclusion of the history and physical examination , skilled clinicians should be able to develop a narrow and accurate differential diagnosis in most of their patients.

2 HISTORY TAKING

A.General history taking

Date: Time: Place:

1. Personal information (put it in one sentence).

- Name
- Age
- Marital status
- Occupation (past / present)
- Address

2. Chief complaints

Ask the patient what are you complaining of ? or what brought you to the hospital ? This must be put in a short statement in the patient's own words. If there is more than one complaint, list them in order of severity or duration .

It is better not to know the diagnosis made by other doctors because it may not be correct . It is better to find out the patient's complaint by yourself.

3. History of present illness

This should record details of each problem using mainly the patient's own words. Let the patient begin by telling the story in their own words without interrupting him. Afterward, ask specific questions, using terms readily understood by the patient, either enlarging upon or clarifying symptoms. Include the answers to the direct questions concerning the system involved (e.g. if the patient is complaining of indigestion you should ask other questions about the gastrointestinal system) and any other system involved in the present complaint are delivered at this stage. Record accurately for how long the complaint has been present and include the sequence of events in chronological order by dates. If the patient has had similar symptoms in the past, obtain detailed information with dates including any treatment received and the results of any investigations. Results of procedures or operations done for him should be accurately documented. Sometimes you need to talk to the relatives of the patients or witness to take history when the patient is poor historian, unable to give history or you suspect that he is giving unreliable information.

4. Systemic review (see next section)

5. Past medical /surgical history

Previous illnesses or operations may have a direct bearing on the current health of the patient. The patient may think that he has a particular diagnosis already made in the past, but careful questioning may prove this unlikely. Note all the other illnesses, operations , accidents , and ask specifically about diabetes, hypertension, bronchial asthma, allergies, tuberculosis, jaundice, bleeding tendencies, blood transfusion, contact with carriers of human immunodeficiency virus, and any admission to hospital together with their dates in details.

6. Drug and allergy history

Ask about any drugs that have been taken in the past and for what condition. Ask especially about insulin, antihypertensive , anticoagulation drugs, steroid, NSAID, chemotherapy, radiotherapy, oral contraceptive pills, hormonal replacement therapy, anti-depressant and diuretics. Mention any allergies to drugs. You should inquire about doses and since how long have these been taken. Ask about immunization and allergy. If the patient is sensitive to any drugs or any topical applications such as adhesive plaster , write it in a clear large letters on the front of the notes.

7. Family history

Ask about the state of health or cause of death of parents, grandparents, brothers, sisters, siblings, other close relatives and any serious familial illness. Question whether any members of the family are suffering or have suffered from the presenting condition. It often helps to draw a family tree.

8. Social history and habits

- Marital status
- Level of education
- Living accommodation
- Past and present occupation - details of work (paying special regard to contact with hazards such as dusts and chemicals)
- Traveling abroad
- Recreational activities
- Drug abuse

- Smoking in details. Inquire about the type (cigarettes, cigar or pipe), frequency, quantity and duration of their smoking habit.
- Alcohol intake in details (type , quantity and duration).

SYSTEMIC REVIEW (DIRECT QUESTIONS)

Every patient should be asked direct questions in all the body systems according to the clinical presentation of the patient. Answers to such questions may have strong relation to the present complaint or it may reveal the presence of other medical or surgical disorders that may affect the management of the present disease. Therefore positive or negative answers must be recorded .

1. Gastrointestinal tract

- Appetite ?
- History of recent diet ?
- Weight changes ?
- Taste changes and teeth problems ?
- Water brash (this is sudden filling of the mouth with watery fluid - saliva) ?
- Acid brash (this is sudden filling of the mouth with acid tasting fluid – gastric acid) ?
- Regurgitation (it is the effortless return of gastric contents into the mouth) ?
- Nausea ?
- Vomiting ?
- Haematemesis ?
- Dysphagia (swallowing difficulty) ?
- Odynophagia (painful swallowing) ?
- Heartburn (it is a retrosternal burning sensation caused by the reflux of gastric acid into the esophagus) ?
- Indigestion (vague symptom) , ask exactly what the patient means ?

- Abdominal pain ?
- Abdominal distension ?
- Flatulence ?
- Constipation ?
- Diarrhea ?
- Tenesmus (urgent , painful but unproductive desire to pass stool) ?
- Painful defecation ?
- Rectal bleeding (haematochezia or melena) and passage of mucus ?
- Incontinence (flatus , fluid or faeces) ?
- Prolapse (dose anything comes out of the anus on straining) ?
- Jaundice (yellow eyes or skin) ?
- Dark urine ?
- Pale stools ?

2. Respiratory system

- Dyspnea (shortness of breath) ?
- Tachypnea ?
- Cough ?
- Chest pain ?
- Sputum ?
- Voice change ?
- Haemoptysis (patient coughing up blood) ?
- Exercise tolerance ?
- Wheezing ?
- Fever ?
- Night sweating ?
- History of pneumonia or tuberculosis ?

- Recent chest X-ray ?

3. Cardiovascular system

- Dyspnea ?
- Palpitation (episodes of tachycardia which the patient notices as a sudden fluttering or thumping of the heart in the chest) ?
- Paroxysmal nocturnal dyspnea (breathlessness that awake the patient at night) ?
- Chest pain or pressure (cardiac pain is usually retrosternal but can be epigastric. It is constricting or band like in nature and usually brought on by exercise or excitement and may relieved by rest . It radiate to the neck or to the left arm) ?
- Orthopnea (dyspnea on lying flat) ?
- Cough ?
- Sputum ?
- Dizziness ?
- Headache and blurred vision ?
- Ankle swelling ?
- Pain in the calves on walking (claudication) ?
- Walking distance ?
- Pain in the limb at rest (rest pain) ?
- Paraesthesia in the limbs (tingling and numbness) ?
- Blue hands or feet (peripheral cyanosis) ?

4. Metabolic and endocrine

- Fatigue ?
- Tremor ?
- Alteration in weight ?
- Alteration in appetite ?
- Polyuria ?

- Polydypsia ?
- Night sweating ?
- Weather preference (cold or hot) ?
- Time of secondary sex characteristics appearance ?
- Menstrual cycle changes ?
- Libido changes ?
- Headache ?
- Swelling in the neck ?
- Change in the general appearance, hair, skin or voice ?
- Any change in hat, glove, or shoe size (acromegaly) ?
- Recently feeling unusually thirsty ?

5. Genitourinary system

- Pain (loin , groin or suprapubic regions) ?
- Thirst ?
- Fluid intake ?
- Frequency of micturition ?
- Urgency ?
- Dysuria (painful micturition) ?
- Polyuria (excessive volume and frequency of urine) ?
- Colour of urine ?
- Haematuria ?
- Pneumaturia (gas bubbles with micturition) ?
- Polydypsia ?
- Any change in urine stream ?
- Hesitancy (delay before starting to pass urine) ?
- Dribbling (at the end when passing urine) ?

- Nocturia (getting up at night to pass urine) ?
- Incontinence (involuntary leaking of urine) ?
- Uremic symptoms (headache, fits, visual disturbance, vomiting , ankle oedema , hand or face oedema) ?

For male

- Pain in the penis or urethra during micturition and intercourse ?
- Urethral discharges ?
- Impotence (erection or ejaculation dysfunctions) ?
- Any rash or lumps on the genitals skin ?
- Scrotal swelling ?

For female

- Date of menarche and menopause ?
- Frequency, quantity and duration of menstruation ?
- Regularity of menstruation ?
- Dysmenorrhea (excessive menstrual pain) ?
- Menorrhagia (excessive menstrual bleeding) ?
- Dyspareunia (painful intercourse) ?
- History of rash or lumps on the genitals ?
- History of venereal diseases ?
- History of miscarriages ? (remember that the gravida number is the number of pregnancies and the para number is the number of birth of babies of over 20 weeks' gestation) ?
- History of high blood pressure or diabetes during pregnancy ?
- History of prolapse of vaginal wall or cervix ?
- History of urine incontinence especially when coughing or straining (stress incontinence) ?
- History of breast symptoms (pain , lump , nipple bleeding or discharges) ?
- Results of previous mammogram ?

6. Nervous system

- Headache ?
- Fainting attacks ?
- Fits ?
- Problems with memory or concentration ?
- Disturbance of consciousness ?
- Visual disturbance ?
- Diplopia (double vision) or other trouble in seeing or hearing ?
- Dizziness or vertigo ?
- Dysarthria ?
- Dysphagia and regurgitation ?
- Left or right handedness ?
- Muscle weakness and paralysis of the limbs ?
- Sensory disturbance and paraesthesia (tingling - pins and needles) in the limbs ?
- Excitability and nervousness ?
- History of stroke or serious head injury ?
- Difficulty in sleeping ?
- Feeling sad or depressed or suicide attempt ?
- Changes in patient's behavior and reactions to others (you may need to ask close relatives) ?

7. Musculoskeletal system

- Pain in the muscles , bones or joints ?
- Weakness in the muscles ?
- Swelling of joints ?
- Limitation of joints movements ?
- Disturbance of joints ?
- Back or neck pain ?

Checklist of history taking
General history taking
1) Personal information
2) Chief complaints
3) History of present illness
4) Systemic review
5) Past medical/surgical history
6) Drug and allergy history
7) Family history
8) Social history and habits
Systemic review (direct questions)
1) Gastrointestinal tract
2) Respiratory system
3) Cardiovascular system
4) Metabolic and endocrine
5) Genitourinary system
6) Nervous system
7) Musculoskeletal system

Description of important symptoms in surgical patients

Appetite

- Increased ?
- Unchanged ?
- Decreased (is it caused by a lack of desire to eat or is it because eating always causes pain or vomiting) ?

Diet

- Type of food ?
- Time of meals ?
- Is the patient vegetarian ?

Teeth and taste

- Can the patients chew their food ?
- Do the patients get odd tastes ?
- Are there water brash (sudden filling of mouth with watery fluid) or acid brash (sudden filling of mouth with acid-tasting fluid) ?

Dysphagia

- The type of food that cause dysphagia (fluid, solid or both) ?
- The level at which the food sticks ?
- Duration of dysphagia ?
- Progression of dysphagia ?
- Is the swallowing painful ?

Regurgitation

- What is the contents (is it bilious , blood , clear fluid, digested or undigested foods) ?
- Frequency of regurgitation ?
- What are the precipitating factors (stooping or straining) ?
- Associated symptoms (epigastric pain or retrosternal heart burn, vomiting , or nausea) ?

6. Flatulence (belching)

- Dose the patient belch ?
- Frequency ?
- Associated symptoms (e.g. abdominal distension, nausea , vomiting)?

7. Heart burn

- Frequency ?
- Precipitating factors (lying flat or bending over) ?
- Relieving factors ?
- Associated symptoms (e.g. regurgitation) ?

8. Vomiting

- Frequency ?
- Volume ?
- Colour ?
- Timing ?
- Nature (clear gastric fluid , bilious , digested or undigested food) ?
- Containing blood ?
- Preceded by another symptoms (e.g. abdominal pain , nausea , headache or giddiness) ?
- Does it follow eating ? How soon ?
- Is it effortless / projectile ?

9. Haematemesis

- Frequency ?
- Volume ?
- Nature (old "coffee grounds" or fresh blood) ?
- Preceded by any symptoms (e.g. epigastric pain, frequent vomiting or retching) ?

- History of coughed-up blood (haemoptysis) ?
- History of recent nose bleeding (vomiting up swallowed blood) ?

10. Abdominal pain or indigestion

- Ask about the features of the pain (site, time of onset, severity, nature, progression, duration, radiation, course, precipitating , exacerbating and relieving factors) ?

11. Abdominal distension

- When did the patient notice abdominal distension ?
- How has it progressed ?
- What brought it to the patient attention?
- Is it constant or variable ?
- Does it affect respiration ?
- Relieving factors (belching, vomiting, defecation, analgesia) ?
- Aggravating factors ?
- Associated symptoms (pain, vomiting, constipation, weight loss, etc…) ?

12. Defecation

- What is the usual frequency of the defecation for the patient and how does it changed ?
- Colour (brown, black, pale, white or silver) ?
- Consistency (hard, soft or watery) ?
- Size (bulky, pellets, string or tape like) ?
- Specific gravity (float or sink) ?
- Smell ?
- Is it containing blood ?

13. Diarrhea

- Urgency ?
- Frequency ?

- Consistency ?
- Timing ?
- Colour ?
- Bloody ?
- Incontinent ?
- Associated symptoms (tenesmus , pain , fever) ?
- Remember that diarrhea and constipation are not precise words . Ask what is normal for the patient (frequency , consistency , colour) ?

14. Rectal bleeding

- Frequency ?
- Volume ?
- Nature (bright red or dark blood) ?
- Relation to stools (mixed in with the stool , on the surface of the stool or it only appear after the stool had been passed) ?
- Associated symptoms (abdominal pain, vomiting, haematemesis , tenesmus) ?

15. Flatus, mucus, slime

- Passing more gas than usual ?
- Passing mucus or pus ?
- Painful defecation (before, during, after or at time unrelated to defecation) ?
- Associated symptoms (abdominal pain and distension , rectal bleeding , diarrhea , weight loss) ?

16. Prolapse

- Does any mass tissue come out of the anus on straining or after defecation ?
- Does this mass tissue return spontaneously or has to be pushed back manually ?
- Does the patient has incontinence for flatus or faeces ?

17. Incontinence

- Is the patient continent of faeces, fluid or flatus ?
- Has the patient had any injuries or operations in the anal region in the past ?
- Has the patient had difficult labour in the past ?
- Does the patient has any neurological diseases ?

18. Tenesmus

- Frequency ?
- Does any mass tissue come out of the anus on straining or after defecation?
- Associated symptoms (abdominal pain, distension, per-rectal bleeding, mucus , weight loss , fever) ?

19. Change of skin colour

- Yellowish discolouration of skin and eyes (jaundice) ?
- Since how long ?
- Associated symptoms (abdominal pain, weight loss, loss of appetite, dark urine and skin itching) ?
- Colour of the stool ?
- History of contact with jaundiced patients ?
- History of blood transfusion ?
- History of upper abdominal surgery ?

20. Cough

- Frequency ?
- Timing ?
- Nature (dry or productive) ?
- Precipitating or relieving factors (e.g. change in posture) ?
- Associated symptoms (sputum, dyspnea, chest pain , fever , weight loss) ?

21. Sputum

- Quantity ?
- Colour (white, clear or yellow) ?
- Containing blood ?
- Produced in particular time or position ?
- Associated symptoms (cough , dyspnea , chest pain, fever) ?

22. Haemoptysis

- Frequency ?
- Quantity ?
- Nature (frothy and pink, red streaks in mucus or clots of blood) ?
- Associated symptoms (cough , dyspnea , chest pain , fever , weight loss) ?

23. Dyspnea

- Is it continuous , intermittent or paroxysmal ?
- How many stairs can he climb?
- How far can he walk on a level surface before the dyspnea interfere with exercise ?
- Can he walk and talk at the same time ?
- Is the dyspnea present at rest ?
- Is it made worse by lying down (Orthopnea) ?
- How many pillows does the patient need at night ?
- Does the breathlessness wake him up at night (paroxysmal nocturnal dyspnea) ?
- Exacerbating factors (e.g. allergy to pollens or dust) ?
- Dyspnea with both phases of respiration or expiration ?
- Associated symptoms (wheezing , cough , sputum , fever , chest pain , palpitation , fainting) ?

24. Chest pain

- Site ?

- Severity ?
- Nature ?
- Radiating to the neck or to the left arm ?
- Associated symptoms (cough , sputum , dyspnea , wheezing , fever , palpitation , fainting) ?

25. Palpitation

- Frequency ?
- Regular or irregular ?
- Precipitating factors ?
- Associated symptoms (chest pain , dyspnea , fainting , ankle swelling) ?

26. Peripheral vascular symptoms

- Does the patient get pain in the leg muscles on exercise (intermittent claudicating) ?
- Which muscles are involved ?
- How far can the patient walk before the pain begins ?
- Is the pain so severe that he has to stop walking ?
- How long does the pain take to wear off ?
- Can the same distance be walked again?
- Is there any pain in the limb at rest ?
- Which part of the limb is painful ?
- Dose the pain interfere with sleep ?
- What positions relieve the pain ?
- What analgesics drug give relief ?
- Are the extremities of the limbs cold ?
- Are there colour changes in the skin ?
- Does the patient experience any paraesthesia in the limb such as tingling or numbness ?

C. History of the pain

Pain is an indicator of disease and is frequently the presenting symptom in every body system. It varies with the disease process and the tissue involved, and may be characteristic and diagnostic. Each doctor must therefore develop an efficient and reliable method of questioning the patient closely about each of the following features :

1) Site
2) Time of onset
3) Mode of onset
4) Severity
5) Nature
6) Progression of the pain
7) The end of the pain
8) Duration
9) Relieving factors
10) Exacerbating factors
11) Radiation
12) The cause of the pain

1. **Site:** the site of the pain is a good indicator of its origin. Ask the patient where the pain is and to point to the area of maximum intensity. Ask if the pain is localized or diffuse. Ask about the depth of the pain. Patient can often tell you whether the pain is near to the skin or deep inside (e.g. the abdomen).

2. **Time of onset:** record the time of onset. For example sudden onset of severe right upper quadrant pain on 17th September 2012 at 3:00 p.m. (2 days ago), but you should record the date of examination at the starting of your note.

3. **Mode of onset:** record the way the pain began (sudden onset at maximum severity, sudden onset and subsequent decline or gradual onset). Sudden onset pain typically associated with injury, with blocking or ruptures of an artery (e.g. abdominal aortic aneurysm) and rupture of a viscus (e.g. perforated peptic ulcer) and most patients are able to remember the precise time of onset.

4. **Severity:** assess severity by its effect on the patient lifestyle (they have had to stop work), sleep and use of analgesia . Sometimes there may be a desire to impress the doctor on the extent of the problem or conversely to play down the symptom for some personal reason.

5. **Nature:** it is very difficult for the patient to describe the nature of their pain. The terms used can be linked to previous experiences – common terms are

aching, burning, throbbing , stabbing, constricting, distending and colic. You should help your patient to describe his pain nature, however if he cannot , do not press the point.

6. **Progression of the pain:** describe the progression of the pain (steady, gradual decline, gradual worsening or fluctuating). Pain may fluctuate with total relief between bouts (e.g. colic).

7. **The end of the pain:** spontaneous or brought about by some action by the patient or doctor. Describe how the pain ended (gradual or sudden).

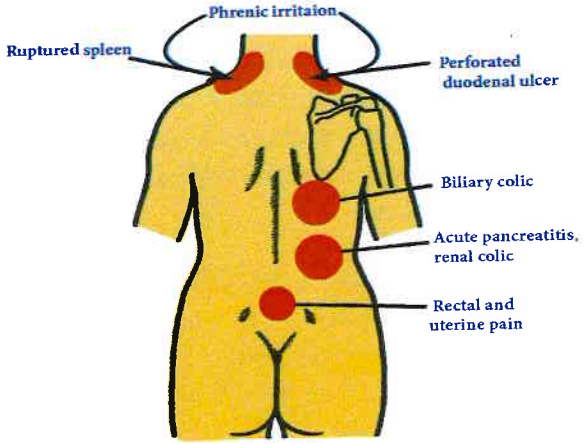
8. **Duration:** always record the duration of the pain in your note although it is apparent from the time of its onset and end.

9. **Relieving factors:** including analgesics, specific medications, specific postures, and eating.

10. **Exacerbating factors:** including eating, movement, and certain postures. It is perfectly reasonable to ask direct questions about those stimuli which you think might affect a pain if the initial description has indicated its source.

11. **Radiation:** record the time and direction of any radiating pain. Remember to ask if the nature of the pain changes at the time it moved.

12. **The cause of the pain:** make note of the patient's opinion of the cause of the pain. The patient may know the cause of the pain.



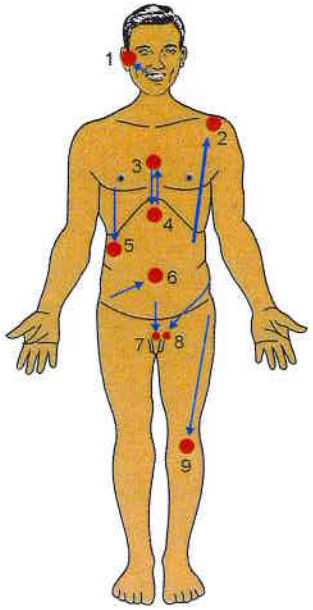
The sites on the posterior surface of the body to which pain is referred in acute abdominal conditions

Definitions related to the pain

a. **Radiating pain** is the extension of the pain to another site whilst the initial pain persist e.g. posterior penetrating duodenal ulcer will have persistent pain in the epigastrium at the same time patient will feel pain in the back.

b. **Referred pain** is a pain which is felt at a distance from its source, caused by the inability of the central nervous system to distinguish between visceral and somatic sensory impulses e.g. inflammation of the diaphragm will cause a pain which is felt at the tip of the shoulder.

c. **Tenderness** is a pain which occurs in response to a stimulus, such as pressure from the doctor's hand, or forced movement. It is possible for a patient to be lying without pain and yet have an area of tenderness. Thus, tenderness can be both a symptom and physical sign. "*The patient feels pain-the doctor elicits tenderness*".



Common Referred pain

	Site of Pathology	Site of Referred Pain
1	Tongue	Ear
2	Diaphragm	Shoulder
3	Stomach	Chest
4	Heart	Epigastrium
5	Pleura	Hypochondrium
6	Appendix	Umbilicus
7	Bladder	Penis
8	Ureter	Testis
9	Hip	Knee

3 LUMP, ULCER, SINUS AND FISTULA

HISTORY OF THE LUMP

Most patients should be able to give you a helpful history about the clinical features of the lump because they frequently feel it . In a patient with lump you should take complete history as usual and ask the following questions in the history of present illness.

large lump over the left shoulder

1) When was the lump first noticed ? (e.g. the lump was first noticed 3 months ago).
2) What made the patient notice the lump? (e.g. pain , during washing or someone else notice the lump)
3) What are the symptoms related to the lump? (describe the detailed history of each associated symptoms e.g. pain , dysphagia)
4) Has the lump changed since it was first noticed ? (e.g. size, shape , colour , tenderness)
5) Does the lump ever disappear? What makes the lump to reappear ?

(e.g. hernia may disappear on lying down and reappearing during exercise)

6) Has the patient ever had any other lumps ? (important connecting history may exists between the present lump and previous or coexisting lumps)
7) What does the patient think caused the lump? (the lump may follow trauma or surgery e.g. hernia)
8) Some lumps may discharge, in which case question the quantity, colour, consistency and smell of the contents.
9) What treatment has been suggested or administered?